

Initial Home Care Survey Checklist

Agency Name: _____

City: _____

Date: _____



Policies & Procedures	
Administrative Policies	
<input type="checkbox"/>	Evidence that applicant has previously owned/operated a HC agency {.0903a}
<input type="checkbox"/>	Evidence of DHSR approved HC training course (as applicable) {.0903a}
<input type="checkbox"/>	Agency Organization Chart {.1001a (8)}
<input type="checkbox"/>	Evidence of premise for operation {.0903 (b)(c)}
<input type="checkbox"/>	Geographic Service area {.1001(g)}
<input type="checkbox"/>	Agency Director job description {.1001(b)(d)(e)}
<input type="checkbox"/>	Companion Sitter Agency Director job description {.1503 1(a)(b)}
<input type="checkbox"/>	Service Supervisor job description {.1001(c)(d)}
<input type="checkbox"/>	Job Descriptions for other categories {.1003(e)}
<input type="checkbox"/>	Annual projected budget {.1002(a)}
<input type="checkbox"/>	Infection control policies {.1003(a)} including: Communicable Disease Control
<input type="checkbox"/>	Blood borne pathogen policy and contents
<input type="checkbox"/>	TB test policy and contents
<input type="checkbox"/>	Hepatitis B immunization/declination policy
<input type="checkbox"/>	Exposure control plan or policy
<input type="checkbox"/>	Employee risk categories identified
<input type="checkbox"/>	Post exposure follow-up plan/policy
<input type="checkbox"/>	Annual program evaluation policy {.1004 (a-e)}
<input type="checkbox"/>	Quarterly client record review policy {.1004(d)}
Client Care Policies	
<input type="checkbox"/>	Scope of Services policy {.1100}
<input type="checkbox"/>	Scope of Services policy {.1502}
<input type="checkbox"/>	Service policies per service categories {.1102 - .1109}
<input type="checkbox"/>	Coordination and referral policy {.1001a11 & .1101a (8)}
<input type="checkbox"/>	Quarterly Supervision of IHAs {.1110 (d,e, f, g, h, & i)}
<input type="checkbox"/>	Supervision of Companion, Sitter & Respite {.1504 1-6}
<input type="checkbox"/>	Admissions /Acceptance policy {.1101 (1-8)}
<input type="checkbox"/>	Discharge policy {.1402 2(d)}
<input type="checkbox"/>	Client's rights and responsibilities policy {.1007(a-d)}
<input type="checkbox"/>	No Smoking policy
<input type="checkbox"/>	Agency complaint policy with state hotline number(s) {.1007(c)}
<input type="checkbox"/>	Health Care Personnel Registry reporting policy
<input type="checkbox"/>	Plan of care policy and contents {.1202(a-b)}
<input type="checkbox"/>	Quarterly plan of care review policy {.1202(a)}
<input type="checkbox"/>	Client record storage and retention policy {.1401(c)(f)}
<input type="checkbox"/>	Client record content policy {.1402}
<input type="checkbox"/>	Orders (medication, treatment) policy {.1302}
Personnel Policies and Procedures	
<input type="checkbox"/>	Competency verification, skills validation/checklist policy {.1003e & .1110a,b}
<input type="checkbox"/>	Personnel records policy and content {.1003(d)(e)(f)}
<input type="checkbox"/>	Annual performance evaluation policy {.1003(f)(7)}
<input type="checkbox"/>	In-service training policy {.1003(d)}
<input type="checkbox"/>	Orientation policy {.1003(d)}
<input type="checkbox"/>	Criminal background investigation (SBI) policy {.0906a}

Agency Director

Qualifications of Director (*shall meet one or more of the following*)

1. Health Care Practitioner
2. At least 2 years of supervisory or management experience in home care or any other provider pursuant to G.S. 131E or G.S. 122C; or
3. Bachelor Degree in health, business, or public administration science and has at least one year supervisor/management experience in home care or other licensed health care program.

Agency Director (Companion, Sitter, Respite)

The Agency Director shall be a high school graduate, or be certified under the G.E.D. Program, **and** shall meet one or more of the following qualifications:

1. Health Care Practitioner (*as defined in G.S. 90-640(a)*) or
2. Have one year experience in home care, companion, sitter, or respite services, or any other provider licensed pursuant to G.S. 131E or G.S. 122C.

Name:		
	Yes	No
Signed Job Description		
Application/Resume		
Blood borne Pathogen Training		
Hepatitis B		
PPD/TB		
Home Care Provider Training		

Personnel Record Review

	Service Supervisor	Caregiver RN, NA, IHA, PCA, Companion	Caregiver RN, NA, IHA, PCA Companion
Employee Name			
Job Title			
Hire Date			
Application/Resume			
Signed Job Description			
License Verification			
NA Registry			
HCPR check			
Skills Validation			
Blood borne Pathogen Training			
Hepatitis B			
TB			
Orientation			
Reference checks			
SBI Signed Authorization			

Please include copy of Commercial Lease, Articles of Incorporation, Home Care Training Certificate(s) and Certificate of Workers Compensation.
 ***If you plan to operate your business out of your home please provide proof that your residence has been zoned for the operation of a business.